Bureau of Health Care Quality and Compliance

Approved 5/3/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN388AGC	A. BUILDING _____ B. WING _____	C 04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT JOSEPH CARE HOME-HIGHLAND	456 HIGHLAND AVE RENO, NV 89512

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility from 3/25/11 to 4/18/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 53 Residential Facility for Group beds for elderly and disabled person and/or persons with mental retardation, Category I residents . Complaint #NV00027883 was substantiated. See Tag Y050.	Y 000	RECEIVED MAY 0 2 2011 BUREAU OF HEALTH CARE QUALITY & COMPLIANCE CARSON CITY NV	
Y 050 SS=D	449.194(1) Administrator's Responsibilities-Oversight NAC 449.194 The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.2766, inclusive, and chapter 449 of NRS.	Y 050	The late [redacted] was one difficult client, maybe attributed to to her severe mental illness and med incompliance. St. Joseph together with her guardian Mr. [redacted] could not persuade her otherwise into anything, even showering [redacted] head (always wrapped in a "Babushka" Head cover, [redacted] calls it) did not happen. Please see letter from the desk of Mr. [redacted] to attest to my claim on the matter (Attachment # 1)	5/3/11 OK NW

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

RECEIVED
MAY 0 5 2011
BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN388AGC	A. BUILDING _____ B. WING _____	C 04/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT JOSEPH CARE HOME-HIGHLAND	456 HIGHLAND AVE RENO, NV 89512

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 050	Continued From page 1 This Regulation is not met as evidenced by: Based on interview from 3/25/11 to 4/18/11, the administrator failed to provide oversight and direction to the staff to ensure that the residents receive needed services they required (Resident #1 had head lice and did not get an appropriate treatment for it). Severity: 2 Scope: 3	Y 050	**In the future, I included Item X for mandatory head check requirement before admission.** attachment # 2 **Also, please find our In House Rules on clients head check for lice that we promise we will strictly enforce from now on. (Attachment # 3)**	